

# BILLING POLICY No. 092

# REIMBURSEMENT REQUIREMENTS FOR OUTPATIENT MEDICAL DRUGS

Date of origin: June 19, 2025 Review dates: 10/2025

# **APPLIES TO**

Commercial

- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

#### **DEFINITION**

Priority Health aims to serve members in accordance with our medical policy coverage criteria and in care settings that are both safe and cost-effective. This policy outlines reimbursement requirements for select specialty drugs covered under the medical benefit that must be dispensed by a contracted specialty pharmacy. These requirements ensure consistent, site-neutral management of high-cost medical drugs and reduces markups on facility-sourced drugs. The intent is to make care more affordable for members. Certain specialty medical injectables must be dispensed, and their claims submitted by a specialty pharmacy with which Priority Health has a reimbursement arrangement, unless otherwise authorized by Priority Health. Providers may directly submit a claim for the administration of the medication only.

The Reimbursement Requirements for Outpatient Medical Drugs policy applies when:

- Requested therapy is included on the <u>Medical Drug List</u> with the Site of Service (SOS) restriction denoted.
  - o Examples include, but are not limited to:
    - Keytruda (J9271; Injection, pembrolizumab, 1 mg)
    - Soliris (J1299; Injection, eculizumab, 2 mg)
- 2. A medical injectable drug is administered in an outpatient hospital setting

Drugs covered under this policy are considered safe and cost-effective and may not require drug acquisition from a contracted specialty pharmacy if in-network and administered in:

- A physician's office
- The member's home, where the drug is administered by an in-network home infusion provider
- An ambulatory (freestanding), independent infusion suite
- An outpatient hospital setting contracted under Priority Health's standard fee schedule.

Providers who are not required to follow these reimbursement requirements may still choose to obtain specialty medications through a contracted specialty pharmacy. This option can help reduce financial risk for providers who are concerned about unpredictable drug acquisition costs or reimbursement rates when purchasing high-cost medications directly.

#### FOR MEDICARE

For indications that don't meet the criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD <u>in our Provider Manual</u>.

## POLICY SPECIFIC INFORMATION

### **Contracted pharmacy details**

The following list shows in-network specialty pharmacy providers as of 10/27/2025.

#### 1. Accredo Specialty Pharmacy

1. Prescriptions may be sent directly to Accredo Specialty.

Phone: 877.222.7336
 Fax: 888.979.8904

#### 2. Optimed Specialty Pharmacy

1. Prescriptions may be sent directly to Optimed Specialty Pharmacy.

2. Phone: 877.385.0535 3. Fax: 877.326.2856

Additional contracted specialty pharmacies may be utilized when coordinated in advance with Priority Health. This list is not all-inclusive and is subject to change based on contractual agreements.

#### Drugs subject to

Review Priority Health's <u>Medical Drug List</u> to verify the medications subject to the Reimbursement Requirements for Outpatient Medical Drugs policy. Providers should refer to this list to determine if a requested drug will require specialty pharmacy. Priority Health's Medical Drug List can also be found <u>in</u> our Provider Manual and/or the Medical Drug List - Search tool

**Drug coverage may still require prior authorization under this policy.** Drug coverage criteria can be found in our Provider Manual. If a requested drug has coverage requirements, a member or provider must submit a prior authorization request and receive a favorable coverage decision before a specialty pharmacy can bill and dispense the requested drug. The request must mention "Specialty Pharmacy" in the "Billing" section of the prior authorization form.

#### Updates to included drugs

Priority Health's <u>Medical Drug List</u> is subject to periodic review and updates following decisions made by Priority Health's Pharmacy and Therapeutics Committee. Priority Health may add or remove drugs as new therapies become available, as pharmacy distribution changes or as cost-effectiveness strategies evolve. Changes to the list will be reflected in the Medical Drug List with effective dates. Providers are responsible for verifying whether medication is on the current list at the time of service.

Requests for exception to the Reimbursement Requirements for Outpatient Medical Drugs policy should be submitted as prior authorization requests to the Pharmacy Department at Priority Health including rationale as to why the request is being made. This can be done by faxing a completed <a href="Medical drug prior authorization form">Medical drug prior authorization form</a> to 877.974.4411. Additional support can be provided by calling 800.942.0954.

For Fully and Self-Funded Commercial Products when drug-acquisition from a contracted specialty pharmacy is not an option, Priority Health requires that patients receive selected infusions or injections to have the infusion or injection in the home or office setting, or an alternative Priority Health-approved site of service. An exception may be considered based on Priority Health's <u>Infusion Services & Equipment medical policy</u>.

#### **Documentation requirements**

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

#### **Modifiers**

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

#### Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

This policy applies to the listed drugs dispensed in an outpatient facility place of service only.

# **DISCLAIMER**

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual

Date	Revisions made
Oct. 2025	<ul> <li>The following updates will be effective Jan. 1, 2026:</li> <li>Changed policy name to Reimbursement Requirements for Outpatient Medical Drugs</li> <li>Expanded policy to apply to in-network (as it previously applied to only out-of-network providers)</li> <li>Expanded definition to clarify when this policy applies and when it may not</li> </ul>